Colorado Department of Health Care Policy and Financing

2020 Nursing Facilities Pay for Performance Application Review

Recommendations Report

June 2020

PUBLIC CONSULTING GROUP

TABLE OF CONTENTS

1. INTRODUCTION

Public Consulting Group, Inc. (PCG) was contracted by the Department of Health Care Policy and Financing (the Department) to review, evaluate, and validate nursing home applications for the 2020 (calendar year 2019) Pay for Performance (P4P) program. This Recommendations Report is supplemental to the 2020 P4P Data Report, which includes final scores, historical data analysis, and a measure by measure data breakdown. This report provides analysis and recommendations for the P4P Program application and process to help ensure continuous program improvement. Considerations for the Department to implement in the P4P Program are based on:

- Observations and feedback throughout the application review process,
- Research into Centers for Medicare and Medicaid Services (CMS) initiatives,
- Other states' P4P programs, and
- A literature review of best practices.

Each section offers specific details on the focus areas identified above and provides recommendations related to the findings and observations.

2. P4P PROGRAM REVIEW

Since its implementation in 2009, the Colorado P4P Program has continuously evolved to ensure that nursing facilities consistently strive to provide high quality care to its residents. Each year, the Department has implemented changes to the application and submission process with the aim of improving clarity, increasing participation, easing administrative burden and encouraging nursing facilities to improve on key quality measures in Colorado. Revisions to the 2020 application included improvements in measures, minimum requirements, and scoring from the previous application period.

To promote program participation and aid the provider submission process, PCG developed a web portal which has been used by nursing facilities to complete and submit applications. The 2020 application cycle marked the fourth year a web portal was used to collect provider submissions. The experiences and feedback from the previous year informed enhancements to the web portal application, aimed at improving user experience from both the applicant and reviewer perspective.

Each P4P application year is unique, therefore this section reports on the following:

- Noted observations throughout the review process,
- Feedback collected from the Department on the application and review process, and
- Analysis of the final scores and measure analysis.

From the information collected above, PCG has outlined opportunities for further application, process, and program refinement.

2.1 P4P APPLICATION

Minimum Requirements Specificity and Standards

Significant progress has been made to reduce the ambiguity of minimum requirement language. There have been multiple iterations of many measures that have been discussed and workshopped during the P4P Committee meetings. While impossible to fully eliminate, the 2020 application cycle resulted in fewer appeals for requirement interpretation than in past years. However, there are still opportunities to further clarify what is considered sufficient documentation.

For example, in *Measure 11-Volunteer Program*, minimum requirement 11-2 states “Documentation of four (4) distinct events where residents have given to others or to their home, i.e. home service project, fundraisers for a home member, resident involvement in charity events, resident to resident volunteer projects, etc.” While most facilities provide documentation such as pictures, some facilities only provide a summary. The documentation technically meets the minimum requirement as no specification for images is provided, but the intent is to have facilities provider more concrete evidence.

Recommendation 1: Review documentation requirement language throughout the application to specify stronger documentation requirements such as images, signed testimonials, sign-in sheets, etc.

The 2020 appeals process had multiple appeals for *Measure 14-Continuing Education*. Due to recent changes to CMS requirements, facilities were required to have an average of 18 hours or more of continuing education per staff member as opposed to a minmum of 14 hours in previous years.

The system calculation does not account for staff who were not employed at the facility for the full year. Therefore, when scoring, the calculation showed that these facilities did not meet the 18-hour requirement, but when calculated outside the portal by PCG staff with weighting to account for partial years, these facilities met the requirement. This issue was not present in previous years because the partial year employees did not reduce the average below 14 hours. This measure will be eliminated in 2021, therefore no specific recommendation for improvement is provided. Rather, the recommendation is

to review the full calculation when changes are implemented, even if it I just the threshold that is impacted.

Recommendation 2: For all measures, review calculation methodology and tools, even when only qualifying thresholds are changed.

Measure 15-Reducing Avoidable Hospitalizations also resulted in a number of appeals. This was due to the reviewer having difficulty locating the required data within documentation provided. Facilities must provide their rehospitalization rates over two one-year periods. However, depending on the reporting system the facility is using, data is not clearly and consistently aggregated for these time periods. Facilities should be instructed to clearly indicate how they calculated their rehospitalization rates and enter this data into a tool to improve the review process and increase consistency in submissions.

Recommendation 3: Instruct facilities to clearly identify their calculation methodology for rehospitalization rates and enter the data into a tool to increase reviewer accuracy.

For *Measure 21- Nursing Staff Turnover Rate*, an upper threshold should be set. Currently, facilities receive points for any improvement in their turnover rate. This year's review process identified an instance of a less than one percent "improvement" in the turnover rate. Likely, this was a result of the facility having less staff in the current year rather than a meaningful reduction in their turnover rate. This facility had over an 85% turnover rate in both years and still received points. The measure should include requirements such as "a turnover rate less than 75% with documented improvement (lower rate) of 5% or greater between 2019 and 2020."

Recommendation 4: Add an upper turnover rate threshold and specify an improvement threshold for Measure 21 to ensure improved rates are more closely linked to improved performance.

PCG has also identified other measures and minimum requirements that could benefit from improved specificity and standards. Minimum requirement 6-1 requests data for the percentage of residents with psychiatric diagnosis, diagnosis or history of alcoholism and/or drug addiction, and residents with a known history of trauma. Facilities are currently uploading documentation with these metrics, however, there is not a standardized format. Therefore, a tool should be created to collect the data. Consideration should be put into whether supporting documentation is also required to verify these statistics, or if the completion of the tool is sufficient.

Recommendation 5: Create a tool to collect statistics required in Measure 6 for better data reporting capabilities.

The text instructions in minimum requirement 13-3 is cut off in the Excel application and portal. It reads "13-3 Submit your CASPER REPORT MDS 3.0 Facility Characteristics Report for third and fourth quarter 2019. From the Characteristics Report submit the following:" The last line should be removed.

Recommendation 6: Modify minimum requirement 13-3 to be clearer by removing the last line. No specific data from the CASPER Characteristics Report is required to be submitted separately.

For *Measure 16.2-16.8 Nationally Reported Quality Measures Scores,* the 2019 application documentation upload tool grouped the measures together for clarity on where to add CASPER reports. This year the feature was disabled. For the 2021 application, this feature should be reintegrated into the portal.

Recommendation 7: Group the Measure 16.2-16.8 documentation upload dropdown together. This will increase clarity for which measure facilities should upload their CASPER reports.

Measure 17.2-Antibioitics Stewardship/Infection Prevention & Control requests CASPER data for the UTI and Catheter quality measures that are very similar to data requested for Measures 16.2-16.8. To make

this measure easier to review, a tool consistent with the one used for Measures 16.2-16.8 should be developed. This will make it easier for reviewers to determine whether the facility qualifies for points.

Recommendation 8: Create a tool to collect data required in Measure 17.2 for better data reporting capabilities and to facilitate accurate review decisions.

Minimum requirement 18-2 is unnecessary. It reads "18-2 Do not enter points for more than one (1) Medicaid Occupancy Average category above. Either four (4) OR three (3) points may be obtained." While it makes sense for the Excel version of the application, facilities can only select one option in the drop down for *Measure 18-Medicaid Occupancy Average*. The portal will automatically calculate the facility's score based on the dropdown. To avoid confusion, the minimum requirement should be removed.

Recommendation 9: Remove minimum requirement 18-2.

For *Measure 19-Staff Retention Rate / Improvement*, there are two options listed in a dropdown for facilities to receive points. However, if a facility is not applying for this measure, it is not clear which option the user should select. There should be an additional option of "Not Applying" to avoid confusion. Additionally, the tool in *Measure 19-Staff Retention / Improvement* will not save unless both percentages, for staff retention rate and retention improvement, are entered. It is recommended that this feature is revised as the measure only requires that one of these statistics meets the measure requirements. Alternatively, minimum requirement 19-1 should be modified to provide specific instructions to input zeroes for the section that is not applicable.

Recommendation 10: Create a "Not Applying" dropdown option for Measure 19 for greater clarity.

Recommendation 11: Update the tool in Measure 19 to save if either section is completed as both sections are not required or update minimum requirement 19-1 instructions to input zeroes for the section not applicable.

For *Measure 20-DON and NHA Retention,* documentation is required. However, facilities are often confused as to what documentation they should provide. It is recommended that documentation should not be required, or instructions should be more specific in what documentation to include, such as proof of hire date.

Recommendation 12: Clarify or remove documentation requirements for Measure 20.

For *Measure 21-Nursing Staff Turnover Rate* the measure requires documentation, however, the type of documentation is not specified which led to questions from facilities, as well as preliminary findings. It is recommended that documentation should not be required, or facilities should be instructed to upload their nursing staff roster. Additionally, there is an error if there are more < 90-day terminations than staff present at the end of the calendar year. This should be fixed as this is situation that could occur.

Recommendation 13: Clarify or remove documentation requirements for Measure 21.

2.2 APPLICATION PROCESS

Web Portal

As mentioned above, this was the fourth year that the entire P4P application was completed, submitted, and reviewed via an online web portal. To build upon the overall success of the online system application last year, enhancements were made to further promote efficacy. It was noted from the 2019 application that matching facilities for per-diem distributions was difficult as facilities have similar names or change names. Therefore, fields for facilities PF and Medicaid IDs were added into the portal. Having these unique identifiers present in a system extract improved the final scoring process from both the PCG and Department's perspectives.

Further system development can be considered to streamline the application and review process. The following improvements can be made to enhance the current application:

- Creating a secondary contact field for each facility to reduce the effects industry turnover has on program communication.
- Requiring tool competition in the portal instead of allowing for equivalent documentation uploads from the Excel application. Documents that are uploaded do not have their data easily accessible for analysis.
    - Add an import from Excel capability to streamline data collection and upload.
- Rollover all facilities' profiles regardless of whether they submitted an application the previous year.
- Hide reviewer scores/comments until 5/1 when decision notices are emailed to avoid early appeal requests. In the 2020 application, some facilities logged in prior to scores being released and tried to submit appeals prior to the official window.

Recommendation 14: Continue to monitor user experience with the application web portal to identify common issues experienced by the nursing home facilities and reviewers. Enhancements to the web portal can lessen administrative burden and streamline the application and review process.

All corrupted files are unable to be identified during the preliminary review process due to the variety of ways corrupted files occur. This year, corrupted files were noted in the Review Notes and facilities resubmitted during the appeals process. A process should be outlined during the review process to remedy corrupted files prior to appeals. Some corrupted files will upload with a distinct file naming convention. This can be reviewed during the preliminary review process. Files that contain 0 bytes are likely corrupted and can also be flagged during the review process. However, some files will remain corrupted without these telltale signs. In that event, during the review process, PCG proposes notifying facilities during the review to obtain needed information instead of waiting until the appeals process to receive the documentation.

Recommendation 15: Explore a review process to identify corrupted files within the preliminary review process. While not a frequent problem, it does delay the review of some facilities.

Preliminary Review Process

This year's review process included a preliminary application review which included identifying instances in which a home may have unintentionally failed to upload a document, or uploaded reports for the incorrect reporting periods. The nursing home would then be given the opportunity to update their application before the final review period commenced. The preliminary review timeline is purposefully brief to ensure adequate time for comprehensive reviews. Within a week after the submission of applications, notifications are sent to facilities with preliminary review findings. Facilities then have one week to upload the corrected documentation for measures specified in their preliminary review findings report. New documentation outside of what was requested in the preliminary review findings is not allowed. The preliminary review, as indicated by its name, is not a comprehensive review and is only meant to catch clear instances of application oversight. It remains each nursing home's responsibility to review their application for completeness and accuracy prior to final submission.

Overall, the preliminary review had at least one finding for 46 facilities, thus giving nursing facilities the chance to resubmit their application with the appropriate documents and earn points that otherwise would have been lost. This was the third year a preliminary review was conducted. Homes completed the process by having their application rolled back, uploading the correct documentation, and resubmitting their application. A major hurdle for the preliminary reviews was getting in contact with facilities. In some cases, the contacts listed in the portal were no longer at the facility and emails were undeliverable. PCG addressed this issue by calling the facility to find alternative contacts. In the future, adding a secondary or management contact field for facilities may reduce this burden.

Recommendation 16: Create a secondary or management contact field for each facility to serve as an extra point of contact and ensure program communication is received by facilities.

2.3 PROGRAM DEVELOPMENT AND PARTICIPATION

There was a slight decrease in program participation between 2020 and 2019. In 2020, 125 facilities submitted applications compared to 138 in 2019. There were 18 facilities that did not reapply in 2020 that applied in 2019. Three of these facilities had substandard deficiencies and were therefore ineligible per the program regulations - “No home with substandard deficiencies, as defined in State Operations Manual, during the previous calendar year will be considered for the current P4P application.” The reasoning for why the other 15 did not apply is unclear.

To gain insight into the decrease in participation, the Department could distribute a short survey to obtain clear reasons why these nursing facilities did not participate. This may be an opportunity for the Department to expand outreach and consider feedback that would encourage greater participation statewide.

Recommendation 17: Reach out to nursing facilities that have created an account on the web portal but did not submit an application in the 2020 P4P program or nursing facilities that did not reapply for the program. Engage these homes through a short survey and follow up as necessary to collect information around barriers to participation.

3. CMS SNF REVIEW

CMS continues to promote initiatives and innovations to improve quality of care at skilled nursing facilities (SNF). CMS began the Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP), which was authorized by Section 215 of the 2014 Protecting Access to Medicare Act (PAMA), in fiscal year (FY) 2019. PAMA includes details about the readmission measures for the program, how facilities will be scored, the performance standards and periods, how facilities can review their scores, and how performance will be reported to the public. The SNF VBP's goal is to support improved clinical outcomes and experiences for skilled nursing facility patients. This program rewards participating skilled nursing facilities based on measures associated with hospital readmissions.

Specifically, CMS measures:

- Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM): "This measure estimates the risk-standardized rate of unexpected hospital readmissions within 30 days for people with fee-for-service Medicare who were inpatients at PPS, critical access, or psychiatric hospitals and for any cause or condition."[1]

The risk-adjusted readmission rate is determined by calculating the standardized risk ratio, then using the standardized risk ratio to calculate a facility-level standardized readmission rate.[2] The standardized risk ratio is the dividend of the predicted number of readmissions and the expected number of readmissions if the same patients were treated at an average facility. The standardized risk ratio is then multiplied with the mean rate of readmission in the population to calculate the facility-level standardized readmission rate.

There are nuances for what is considered as a readmission. For the predicted number of readmissions, hospital readmissions that occur after discharge from the nursing facility, but within the 30-day proximal hospitalization are included. Readmissions identified as planned readmissions or observation stays are excluded. For the expected number of readmissions, stays where the patient has one or more intervening post-acute care admission within the 30-day window, had multiple nursing facility admissions within the 30-day window, or has a gap greater than 1 day between hospitalization discharge and nursing facility admission are excluded. Also excluded are nursing facility stays where the patient did not have at least 12 months of fee for service Part A Medicare enrollment before the hospitalization discharge, where the patient was discharged from the skilled nursing facility against medical advice, or if the principal diagnosis of hospitalization was for cancer, rehabilitation care such as fitting of prostheses and adjustment of devices, or pregnancy. Nursing facility stays where the data is missing or problematic with respect to variables used for rate calculation can also be excluded.

CMS provided a fact sheet[3] regarding SNFRM that provides further insight on how the measure will be used in this program:

- "Hospital readmissions will be identified through Medicare claims. This means that SNFs do not have to report any additional data to CMS,
- Unplanned admissions are identified using a modified version of the CMS Planned Readmissions Algorithm,
- The SNFRM is adjusted to account for patient differences, such as comorbidities, when comparing facility readmission rates, and

[1] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html
[2] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/Top-10-thingst o know-about-SNFRM.pdf
[3] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/Top-10-thingst o know-about-SNFRM.pdf

- CMS will propose to replace the SNFRM with the SNF 30-Day Potentially Preventable Readmission Measure (SNFPPR) in future rulemaking."

All SNFs that are paid under the SNF Prospective Payment System (SNF PPS) will be eligible to receive incentive payments under the SNF VBP. The incentive payments are funded by a two percent reduction in the adjusted Federal per diem rate paid to SNFs for the fiscal year. Sixty (60) percent of this withheld amount represents the total available funding for the incentive payments.[4] Nearly all Colorado P4P SNFs are participating in the SNF VBP.[4]

The FY2019 program evaluated CY17 (January 1-December 31, 2017) data using CY15 (January 1-December 31, 2015) as the baseline period. The FY2020 program will evaluate FY2018 (July 2017-June 2018) data using FY2016 (July 2016-June 2016) as the baseline. The FY2021 and FY2022 programs are also projected to use fiscal year data. CMS utilizes the SNFRM to evaluate if there was any improvement between the evaluated fiscal year and baseline fiscal year. SNFs receive a score based on both their improvement and achievement between the baseline and performance year. CMS uses these scores to develop incentive multipliers. SNFs that earn higher scores receive higher incentive payments than lower performing peers. SNFs with performance scores that are ranked in the lowest 40 percent nationally receive payments at a rate lower than they would have without the SNF VBP.[5]

For the FY2019 program, the national average performance score was 34.5 points. Colorado facilities performed slightly above average with an average performance score of 45.2 points. Nearly a quarter of the facilities from Colorado fell within the national 40th percentile, receiving a lower payment rate than without the VBP program. The P4P application currently has a measure around reducing avoidable hospitalization; however, creating a measure to focus on hospital readmission improvement may initiate processes to increase qualification and reimbursement under the SNF VBP program.

For the FY2020 program, the SNFs participating in the SNF VBP will be receiving a SNF PPS payment rate update. This includes an estimated increase of $851 Million in aggregate payments to SNFs during FY2020. This payment rate update reflects the SNF market basket update, as adjusted by the multifactor productivity (MFP) adjustment. There are also updated requirements for the Skilled Nursing Facility Quality Reporting Program (SNF QRP). These requirements include the adoption of two Transfer of Health Information quality measures and standardized patient assessment data elements that SNFs would be required to begin reporting with respect to admissions and discharges that occur on or after October 1, 2020.[6]

Recommendation 18: ***Continue to monitor the performance of Colorado P4P facilities in the FY2020 SNF VBP.***

Recommendation 19: Since preventable hospital readmissions are the primary focus in SNF VBP, reevaluate how hospital readmissions are currently scored in the Colorado P4P program.

[4]https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18003.pdf [4] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBPPublicReporting-Oct-2017.xlsx

[5]https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18003.pdf

[6]https://www.federalregister.gov/documents/2019/08/07/2019-16485/medicare-program-prospective-payment-system-and-consolidated-billing fo r-skilled-nursing-facilities

4. OTHER STATES REVIEW

Colorado's P4P program is well established and its collaboration throughout the year with nursing home administrators is conducive to continuous improvement. Still, it can be useful for the Department to stay informed of other state's P4P-like programs. This section provides the Department with such information in two ways: we provide updates on other state's programs and include a summary of findings from the previous four P4P Recommendation Reports that are still relevant and may be instructive for any program changes.

TEXAS

As reported last year, Texas's Quality Incentive Payment Program (QIPP) would have significant changes effective September 2019. Component One, for non-state government owned facilities, remains the same. Facilities receive monthly payments determined by the nursing facility's submission of a monthly Quality Assurance Performance Improvement Validation Report. Facilities are eligible for up to 110 percent of the non-federal share of the QIPP program.

A fourth component was added. Component Four is available to all facilities by meeting national benchmarks or showing minimum or strong improvement, respectively, on the following measures:[7]

- Percent of residents with a urinary tract infection,
- Percent of residents whose pneumococcal vaccine is up to date, and
- The facility has an infection control program that includes antibiotic stewardship.

Component Four receives 16 percent of QIPP funds. Funding for the second and third components was also changed. Originally Components Two and Three received the remaining funds after accounting for Component One's needs. Components Two and Three now receive the remaining funds after accounting for Component One and Four's needs. Component Two originally received 35 percent of remaining funds. Component Two now receives 30 percent of remaining funds. Component Three used to receive 65 percent of remaining funds and now receives 70 percent of remaining QIPP funding.

Components Two, Three, and now Four have funding distributed quarterly if facilities meet specific quality measures. Component Two's quality measures approved by CMS are related to Workforce Development and include measures such as:[8]

- Maintaining four additional hours of registered nurse (RN) staffing coverage per day, beyond the CMS mandate,
- Maintaining eight additional hours of RN staffing coverage per day, beyond the CMS mandate, and
- Presence of a staffing recruitment and retention program that includes a self-directed plan and monitoring outcomes.

Component Three's quality measures are three CMS 5-Star Rating Quality Measures:[9]

- Percent of high-risk residents with pressure ulcers, including unstageable pressure ulcers,
- Percent of residents who received an antipsychotic medication, and
- Percent of residents whose ability to move independently has worsened.

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[7] https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/qipp/qipp-final-quality-metric-packet-fy-2020.pdf
[8] https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/qipp/qipp-final-quality-metric-packet-fy-2020.pdf
[9] https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/qipp/qipp-final-quality-metric-packet-fy-2020.pdf

Improvement is measured from a baseline value, determined for each facility as the average performance for the four quarters prior to the first day of the eligibility period. A minimum improvement is defined as a 1.7 percent improvement each quarter, adding to a 7 percent improvement by the end of the yearlong eligibility period. A strong improvement is defined as a 5 percent improvement from baseline quarterly, adding to a 20 percent improvement by the end of eligibility period.

For next year's QIPP program, no changes have been proposed.

SUMMARY OF PREVIOUS INFORMATION COLELCTED ON OTHER STATES' PROGRAMS

Minnesota

On January 1, 2016, Minnesota Legislature authorized a new system for nursing facility reimbursement rates, which the Department of Human Services calls the value-based reimbursement system. Under the value-based system, DHS sets facility reimbursement rates based on the cost of providing care to residents. Although the new system ties a facility's rate to its costs, DHS will not reimburse the facility for unlimited costs; a facility's rate will only reflect its care-related costs up to a limit. If a facility's care-related costs are greater than its limit, the facility's rate would not reflect the portion of the costs more than the limit. As with previous systems, facilities' rates are case-mix adjusted—facilities receive higher rates to care for more-resource intensive patients.

Within the value-based reimbursement system, Minnesota has implemented payments and rewards for high quality nursing facilities. Currently, DHS and the legislature have attempted to improve and reward nursing facility quality using three main strategies. First, DHS encourages facilities to improve their quality of care by publishing the Minnesota Nursing Home Report Card system. Second, the new value-based reimbursement system sets a limit on a facility's care-related reimbursement rate, and this limit is tied to the facility's quality score. Third, DHS operates two incentive programs that reward facilities who undertake quality improvement projects with rate increases.

The Minnesota Nursing Home Report Card

The Minnesota nursing home report card provides patient quality profile data of the nursing facilities in Minnesota based on three separate data sources. The first is a survey of residents in every facility on the quality of the nursing home and is conducted by a private contractor. The second are state inspections by the Minnesota Department of Health and the third are quality indicators that DHS derives from the comprehensive assessments and inspections conducted by MDH. These assessments are then broken down into (8) different quality measures so that patients can use the scores provided to make accurate choices. These quality measures include:

- Resident Quality of Life
- Family Satisfaction
- Clinical Quarterly Indicators
- State Inspection Results
- Hours of Direct Care
- Staff Retention
- Use of Temporary Nursing Staff
- Proportion of Beds in Single Rooms

Quality in the Value-based Reimbursement System

The value-based reimbursement system, effective January 1, 2016, builds a quality component into the operating payment rate by placing limits on care-related rates using a facility's quality score. For example, a facility with a higher quality score is subject to higher limits. These quality scores are calculated using the department's nursing facility quality profiles and are measured on a scale between 0-100. Fifty points of the score are based on a facility's quality indicator score which are derived from the Minimum Data

Set's comprehensive assessments conducted at the facility. Forty points of the score comes from the, "resident quality of life score" from the survey of the facility's residents. The last 10 points come from the facility's, "state inspection results score."

Incentive Programs: PIPP and QIIP

DHS administers two programs that offer facilities time-limited rate adjustments to implement projects that improve the quality and efficiency of care. The Nursing Home Performance-based Incentive Payment Program (PIPP) awards rate increases on a competitive basis and is available to a limited number of facilities each year. In contrast, the Quality Improvement Incentive Program (QIIP) is a broader program that is open to any facility reimbursed under Medical Assistance.

PIPP has been offered since July 1, 2006 and has allowed facilities to apply for a time-limited rate increase in exchange for implementing a program designed to increase the quality of the facility. There is a competitive application process to see which facilities receive the funding as individual facilities or a collaboration of multiple facilities can apply. Facilities can request up to a 5 percent increase in their current payment rate. These facilities will receive the extra funding as long as they maintain projected program outcomes. Some of these programs DHS has provided funding for include improvement in employee recruitment and retention, reduce the rate of falls among residents, and improve residents dining experiences.

QIIP is a more recent incentive program authorized by the 2013 Legislature which went into effect on October 1, 2015. In contrast to PIPP, this program eliminates the competition and allows all facilities to take part in a rate increase. To participate in the process, a facility only needs to select a single quality indicator and work to improve that measure. These quality measures are split up into 38 individual measures and a facility may pick from a list of 26 "quality indicators" or 12 "quality of life domain scores." The rate increase is determined of the amount of improvement seen in the selected quality measure relative to the previous year. The goal is to improve rates by one standard deviation.

Oklahoma

On July 1, 2007, the Oklahoma Health Care Authority (OHCA) implemented the Focus on Excellence program which is designed to measure and ensure the integrity, quality and overall wellness of consumers and Long-Term Care (LTC) facilities. Every LTC facility in Oklahoma can participate in the program. There are currently 290 actively participating facilities.[10] The program has two components, an incentive methodology tied to nursing facility performance against defined quality criteria, and a star rating system published on a website accessible to consumers. Both rely on the quality measures meant to encompass three different areas of satisfaction: the resident, family, and employee.

Quality data is collected through multiple mechanisms. Quality of Life data is collected through surveys circulated to nursing facilities for distribution to all residents within the facility, no matter the type of payer they were associated with. Respondents have four choices of answers: either agree strongly, agree, disagree, or disagree strongly. Family members also complete the survey, which is mailed to their homes. Quality of care is determined using data on facility direct care staffing hours from the OHCA monthly. Facilities are required to submit the data to the OHCA on a Quality of Care report which is used to calculate the ratio of Medicare Part A days to Medicaid days.

Georgia

Georgia's Department of Community Health (DCH) operates a P4P program with collaboration from nursing home providers, and consumer groups to raise the quality of care for the 40,000 Georgia citizens who live in the state's nursing facilities. Similar to OHCA, DCH used nursing home performance information through My InnerView, a software and service for nursing facilities to monitor performance

[10] https://www.okhca.org/individuals.aspx?id=8135

and quality measures and determine the quality incentive payments. My InnerView has research showing that state nursing facilities that take place in the statewide quality initiative achieve results, such as reducing resident falls, the use of physical restraints, and antipsychotic medications, as well as a reduction in staff turnover rates.

In 2007, 78 percent of facilities applying to the program received incentive payments.[11] In 2009, DCH continued the incentive fee program for nursing facility providers who met specific criteria for quality measures, adding a 1 percent additional increase to the incentive payment through legislative mandate that began in FY 2010. Over 89 percent of all facilities participating in the program were awarded the incentive fees.[12]

California

California's Quality Accountability Supplemental Payment Program (QASP) has been in operation since 2014 due to the passage of SB 853.10. The State also refers to the QASP program as the Quality Accountability Program for Skilled Nursing Facilities. The California Department of Public Health (CDPH) partners with the California Department of Health Care Services (DHCS) to implement QASP. To help DHCS issue incentive payments, CDPH's Center for Health Care Quality assesses and scores each facility's quality of care for its residents. For State Fiscal Year 2017, CDPH and DHCS established new quality measures and point allocations for QASP evaluations. Due to CMS's 2018 removal of the worsening pressure ulcer status quality measure, California is creating their own pressure ulcer measure to be incorporated.[13] New measures and point allocations are subject to change in each State Fiscal Year. Currently, QASP's quality measures are broken down into two categories: Measurement Areas and Quality Measures. In the Measurement Area, the subcategories include Pressure Ulcer Measurement Area, Immunizations Measurement Area, and 30-Day All-Cause Readmission. In the Quality Measure category, Staff Retention, Control of Bowel/Bladder: Long Stay, and Pneumococcal Vaccination: Short Stay are some of the subcategories. Compared to pay for performance programs in other states, QASP is much narrower in focus. However, QASP designates $81 million in Quality payments and $9 million in Improvement payments.[14] In other words, QASP rewards yearly improvement in facilities.

Recommendation 20: Explore dedicating funds for rewarding nursing facilities who show an improvement in their application scores. This would be a modification of California's structured payment program. Specific to Colorado, the Department could potentially provide a financial incentive for homes who score 0-20 points, thus not meeting the threshold to receive any per diem add on. These homes may be discouraged from applying. Some amount of financial incentive to encourage the home to continue building its program to meet P4P measures may increase program participation in future years.

New York

New York has participated in a nursing facility pay for performance program since 2008.[15] Currently, the state's program is referred to as the Nursing Home Quality Initiative (NHQI). NHQI is an annual quality

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11 https://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit_1210/3/39/167346932FY09AnnualReportredu.pdf

12 https://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit_1210/3/39/167346932FY09AnnualReportredu.pdf

13 https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/CDPHCASpecificPressureUlcersF1.pdf

14 http://www.cahf.org/Portals/29/QCHF/2017/QASP%20DON.pdf?ver=2017-02-08-112725-853

15 http://www.ltccc.org/publications/documents/LTCCCP4Preportfinal08.pdf

and performance evaluation project that focuses on improving the quality of care for residents in Medicaid-certified nursing facilities across the state of New York. The current NHQI is based on the previous calendar year's performance and is worth 100 points. Nursing facilities are awarded points for quality and performance measures in the components of Quality, Compliance, and Efficiency. Specific deficiencies cited during the health inspection survey process are also incorporated into the results. The points for all measures are then summed to create an overall score for each facility. Facilities are ranked into quintiles based on their overall scores. Quintile one represents the top-performing facilities while quintile five represents the lowest-performing.

The New York State Department of Health website contains information and results for each year of the NHQI. After downloading from the website, the quintile ranking documents contain the following worksheets: nursing facilities in each of the five quintiles, nursing facilities with certain deficiencies cited during the health inspection survey process, and nursing facilities that are excluded from the NHQI for various reasons. Nursing facilities with certain deficiencies are ineligible for ranking, and homes are excluded from the NHQI program if they are:

- Non-Medicaid facilities
- Designated by CMS as a Special Focus Facility at any time during 2015 or 2016, prior to the final calculation of the 2016 NHQI
- Specialty facilities
- Specialty units within a nursing home
- Continuing Care Retirement Communities
- Transitional Care Units

Utah

In Utah, the Nursing Facilities Quality Improvement Incentive (QII) Program is the state's pay for performance program.[16] Based on performance each year, QII uses general fund money to award performance. In total, the QII program has three components-QII(1), QII(2), and QII(3). QII(1) and QII(2) are two independently scored components. QII(1) ensures that quality programs are implemented at the facilities. QII(2) provides incentive for facilities to improve the environment for the residents. QII(2) categories include Patient Life Enhancing Devices, Clinical Software/Hardware, Improved Dining Experience, and Patient Bathing Systems. Scores in either QII(1) or QII(2) are not reliant on the score in the other component.

The final component, QII(3)'s score relies on the previous two components. Specifically, to earn all the points for the QII(3) component, a facility must complete all of the QII(1) forms and at least one QII(2) form. QII(3) ensures resident choices are available. To apply for QII consideration, providers must submit cover forms with checklists and supporting documentation to Utah's Department of Health Medicaid Reimbursement Unit. A complete QII application package includes: Application, Spreadsheet, Invoice(s), Proof of Payment, and a PDF for each incentive and email submission. QII is the longest running program out of the reviewed states, in operation since 2004. Utah has not completed much analysis to relate the resident satisfaction level to the QII payments over the years, however the State meets annually with representatives in the Nursing Facilities industry for input on what works and does not work for providers. Also, funding is 100 percent from the state's general funds.

16 http://health.utah.gov/medicaid/stplan/NursingHomes/QI/UHCA_April_2017_Presentation.pdf

5. BEST PRACTICES

In our review of best practices this year, PCG focused on best practices related to COVID-19. We feel this information is relevant to the P4P committee's current task of adjusting the 2021 P4P Application to account for the effects that the virus has on nursing facilities' operations. This is informed by CMS's published toolkit of practices from varying states.[17] PCG also provides updates to some state's best practices. Like the previous section, PCG reviewed Recommendations Reports from the previous four years to identify if any information was still relevant today.

COVID-19

The following are best practices found regarding infection control.[18] They include practices that facilities can complete, as well as actions the State can take to assist facilities.

- Facilities have designated areas for staff to change clothes upon entry and exit of the facility. Staff may also be required to shower at the end of their shift to reduce potential spread.
- All persons entering the facility are screened.
- Facilities required use of anti-viral shoe spray for anyone entering the facility.
- Facilities are required to report deaths within the facility.
- Facilities cohort patients based on risk. Specific units are created for each risk level with specially trained staff. This includes a COVID-19 positive unit, exposed unit, possible exposure unit, and non-exposed unit. Facilities may also create observation units for transfers.
- Multiple states have adopted the Battelle Critical Care Decontamination System (CCDS)™ to disinfect Personal Protective Equipment (PPE) and materials.
- State agencies serve as a bridge for supplies such as PPE and cleaning supplies. Supplies are distributed to long term care facilities that have requested it due to critically low supply.
- State agencies conduct assessments and audits of cleaning practices by facilities, verifying appropriate cleaning protocols and PPE are used.
- State agencies contract with cleaning companies or having specially trained and equipped National Guard teams assist nursing facilities with disinfection.
- State agencies provide a centralized website with guidance materials with up to date infection control protocols.

Similarly, testing requires cooperation from the State and facilities. However, as the State has the most control over testing resources, there is a significant need for State action. The following are best practices identified:[19]

- Facilities have weekly testing of at least 15 percent of staff and residents when there is not an active COVID-19 case and 100 percent of staff and residents when there is an COVID-19 case.
- Patients are tested prior to transfer from hospitals to long term care facilities.
- The State establishes strike teams to conduct testing at nursing facilities when potential or positive COVID-19 cases are seen in residents or staff members.
- The State creates a mobile outreach unit to conduct testing with emphasis on rural facilities.

[17] https://www.cms.gov/files/document/covid-toolkit-states-mitigate-covid-19-nursing-homes.pdf
[18] https://www.cms.gov/files/document/covid-toolkit-states-mitigate-covid-19-nursing-homes.pdf
[19] https://www.cms.gov/files/document/covid-toolkit-states-mitigate-covid-19-nursing-homes.pdf

Resident activities and interactions have declined due to the high-risk population served in nursing facilities. Provided are some examples of activities and mechanisms residents can stay connected with each other:[20]

- One facility in South Dakota purchased two tandem wheelchair bicycles. The passenger seat is in the front, while the cyclist sits behind the passenger.
- Availability of iPads, laptops, or other technological devices to increase opportunities for resident communication to family and friends.
- Staff dancing in the halls.
- Volunteer opportunities include delivering meals or hosting virtual activities.[21]
- Socially distanced events outside.[22]

Recommendation 21: Innovation is an important part of P4P programs. A best practice sharing mechanism for Colorado facilities can provide new ideas especially in times where best practices are not readily established.

INDIANA

Indiana had some updates to their VBP program. Indiana's VBP program for nursing facilities has a maximum per diem add-on of $14.30 as of 2011. Scores to obtain a per diem add on are based on survey inspections, staffing, and quality of life measures. Indiana updated their scoring system for FY19-20. Scoring factors are their weights are:

- 30% determined by long-stay measures from CMS 5-star quality,
- 55% from health inspection domain of CMS 5-star quality,
- 10% from staffing domain (PBJ data) of CMS 5-star quality, and
- 5% for Advance Planning Certification.

Beginning in July 2020, these scores will be updated and determined by the following:

- 60% determined by long-stay measures from CMS 5-star quality,
- 25% from health inspection domain of CMS 5-star quality,
- 10% from staffing domain (PBJ data) of CMS 5-star quality, and
- 5% for Advance Planning Certification.

As of July 2013, the add-on formula is:

Per Diem Add-on = $14.30 ((84 – Total Quality Score) X $0.216667)

SUMMARY OF PREVIOUS INFORMATION COLLECTED

Literature Reviews

A recently published paper found that utilizing a smart watch-based communication system could improve call response times.[23] While this is a prototype study, the authors found a 40 percent reduction in response time to call lights to bedrooms, 58 percent reduction in response type to bathrooms, and a 29 percent reduction in response time to bed exit alarms. Further evaluation needs to be completed on

[20] https://www.cms.gov/files/document/covid-toolkit-states-mitigate-covid-19-nursing-homes.pdf
[21] https://www.nationalacademies.org/news/2020/04/how-nursing-homes-are-handling-covid-19-best-practices-from-maryland-and-massachusetts
[22] https://www.nationalacademies.org/news/2020/04/how-nursing-homes-are-handling-covid-19-best-practices-from-maryland-and-massachusetts
[23] https://www.ncbi.nlm.nih.gov/pubmed/31099184

efficacy and logistical barriers for implementation, but this is a novel idea that can improve the quality of care for patients.

Improving staffing ratios is another method of improving quality of care found in the literature. There is a strong positive impact on outcomes with increased nursing staff. However, staffing levels should also consider acuity of residents. CMS does include acuity staffing in their five-star rating methodology (discussed in the next section); however, a study notes that this methodology also underestimates needed staffing levels. Reviewing CMS's methodology, adjusting it to become more accurate, and rewarding facilities that meet or improve their staffing ratios may be a way to promote quality of care in Colorado.

Alabama

The Alabama Nursing Home Association conducts an annual showcase where homes around the state present best practices they developed to improve the quality of care or quality of life for residents. Related to quality of care, one home created an onsite dental program where a local dentist and hygienist provide services onsite.[24] The facility reported a reduction in risk of oral infection and risk of weight loss. They also reported a reduction in transportation costs and extra staff time required to transport residents. Residents do not pay out of pocket, rather, the facility uses Incurred Medical Expense billing to reduce the resident's financial liability to the facility. The facility then receives an increase in Medicaid dollars for the cost of the dental care, resulting the residents receiving dental care while the facility sees no impact to its revenue. Another best practice highlighted by the program was related to quality of life. A facility developed an activity to help individuals with dementia express themselves.[25] Twice a week, themed activity stations are set up with familiar music and activities, such as costume jewelry and blocks of wood. The facility notes that residents feel happier and useful.

Arizona

The Arizona Health Care Cost Containment System (AHCCCS) has implemented a VBP model to financially reward providers. These providers must meet or exceed specific benchmarks to receive payment. Benchmarks are focused on specified quality and cost measures.[26] Arizona's 2016 VBP initiative included five measures, two of which were considered utilization measures, and three that were considered clinical care quality measures. Specific goals included reducing the rate of readmission within 30-days to below 20 percent and also reducing emergency department utilization to below 20 percent. Arizona's 2018 VBP model includes two clinical care quality measurements that are that are focused on improving pneumococcal vaccination rates and influenza vaccination rates.[27] This model allows select AHCCCS-registered providers to meet the two clinical care quality measures to receive a VBP Differential Adjusted Payment. The purpose of these payments is to reward the providers that have proven their commitment to improving patient experiences, improving members' health, and reducing cost of care. These adjusted payments will represent an increase in the current fee-for-service rates.

Ohio

In May 2017, Ohio's State Plan Amendment (SPA) 17-004 was approved to provide enhanced payment rates for nursing facilities that provide services to ventilator-dependent individuals. The payment is based on a per-diem payment rate for ventilator-dependent individuals in nursing facilities that participate in the Ohio Department of Medicaid (ODM) nursing facility ventilator program. The per-diem rate equals 60

[24] https://anha.org/uploads/web/Crowne-Mobile-BP-2017.pdf
[25] https://anha.org/communicating-with-people-unable-to-speak-2/
[26] https://www.azahcccs.gov/AHCCCS/Initiatives/PaymentModernization/valuebasedpurchasing.html
[27] http://www.integratedcareresourcecenter.com/PDFs/ICRC_VBP_in_Nursing_Facilities_November_2017.pdf

percent of the statewide average of the total per Medicaid day payment rate for long-term acute care hospital services for the prior calendar year. The enhanced payment may be reduced by a maximum of five percent if the nursing home's numbers of ventilator associated pneumonia (VAP) episodes exceed the maximum number of VAP episodes determined by ODM for two consecutive quarters.[28] Ohio requires managed care plans to pay the fee for service (FFS) rate, which enables them to pass the enhance payment on to the providers.

New York

New York's Nursing Home Quality Initiative (NHQI) Methodology was updated in March 2017 and is comprised of three components: the Quality Component, the Compliance Component and the Efficiency Component. The Quality Component is calculated using Minimum Data Set (MDS) 3.0 data from the 2016 calendar year, NYS employee flu vaccination data and nursing home cost report data to determine the percentage of contracted and/or agency staff utilized and the rate of staffing hours per day. The Compliance Component comprises CMS' five-star quality rating for health inspections, timely submission of nursing home certified cost reports, and timely submission of employee influenza immunization data. Lastly, the Efficiency Component stems from potentially avoidable hospitalization data.[29] Notably, the recently enacted State Fiscal Year (SFY) 18-19 budget included new initiatives that will impact New York's nursing facilities. The Department of Health will reduce Medicaid revenue to a residential health care facility in a payment year by two percent to the lowest performing Nursing Homes. The two percent reduction will apply if in each of the most recent payment years, the facility was ranked in the lowest two quintiles of facilities based on NHQI performance and was ranked in the lowest quintile in the most recent payment year.

Kansas

The P4P Program in Kansas provides nursing facilities with the opportunity to earn up to $9.50 per diem add per day. The program has two distinct per diem add on measure sets. There is the Quality and Efficiency Incentive Factor, which includes quality of care performance measures. This incentive factor is determined by three outcomes: case mix adjusted nurse staffing ratio, staff turnover and Medicaid occupancy. The per diem add on opportunity for this incentive is up to $5.50. Then there is the PEAK 2.0 Incentive Factor, which includes measures related to person-centered care. For the PEAK Incentive, there are six levels that a home may fall within in adopting person-centered care. Each level is tied to a per diem amount, ranging from $0.50 - $4.00. Accordingly, the per diem add on for the PEAK Incentive can be as much as $4.00.

Minnesota

There are two nursing home incentive-based payment programs in Minnesota. The Performance-based Incentive Program and the Quality Improvement Incentive Payment Program. The former rewards quality improvement through a competitive program that provides an increase in rates of up to 5 percent for up to three years. The nursing facilities assume 20 percent of risk for outcomes on projects they initiate, thus they are guaranteed 80 percent of the state funding. The Quality Improvement Incentive Program allows nursing facilities to choose areas of focus in any quality indicator or quality of life domain. The homes then set improvement goals by one standard deviation over the course of the review year and also must be in at least the 25th percentile. Financial incentives may be as much as $3.50 per resident day. It should be noted that nursing facilities generally do not completely meet their goal and thus receive a prorated per diem. This has ensured that the maximum allowable per diem of $1.75 in the state's funding is not exceeded.

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[28]https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OH/OH-17-004.pdf

[29] https://www.health.ny.gov/health_care/medicaid/redesign/nhqi/2017/docs/methodology.pdf

6. CMS 5-STAR RATING DATA REVIEW

At the national level, CMS has a rating system to allow consumers, families, and caregivers to compare nursing facilities. CMS has acknowledged the difficulty of developing a rating system that addresses all considerations that consumers and families may have when deciding on a nursing home. The rating system described below is meant to be one source of information that should be considered with other factors to best inform a decision on a nursing home for an individual.

CMS employs a 5-star rating system, as such, overall ratings range from one star to five stars, with more stars indicating better quality. As described by CMS, the 5-star ratings are based on the three components listed below. Each component gets its own rating, then an overall rating is determined.

1) Health inspections: this includes reviewing information from the three most recent onsite inspections that include standard and complaint surveys.
2) Staffing: this includes reviewing information regarding the average number of hours of care provided to each resident each day by nursing staff.
3) Quality measures (QMs): this includes reviewing the four most recent quarters of data available for 16 different physical and clinical measures for nursing home residents.

Using the three components, CMS assigns the overall 5-star rating in these steps:

Step 1: Start with the health inspections rating.

Step 2: Add 1 star if the staffing rating is 4 or 5 stars and greater than the health inspections rating. Subtract 1 star if the staffing rating is 1 star.

Step 3: Add 1 star if the quality measures rating is 5 stars; subtract 1 star if the quality measures rating is 1 star.

Step 4: If the health inspections rating is 1 star, then the overall rating cannot be upgraded by more than 1 star based on the staffing and quality measure ratings.

Step 5: If a nursing home is a special focus facility, the maximum overall rating is 3 stars.

Table 1, below, displays each applicant's CMS 5-star rating in additional to their P4P application self-score and the final review score. Out of the 125 applications received, 0 (0%) had a 0-star rating, 10 (8%) had a 1-star rating, 25 (20%) had a 2-star rating, 22 (18%) had a 3-star rating, 27 (22%) had a 4-star rating, and 41 (33%) had a 5-star rating. It can be determined that a 1 or 2-star rating did not deter facilities from applying for the 2020 Pay for Performance program.

Table 1. CMS 5-Star Rating Data with 2020 P4P Scores.

Facility Name	2020 Self Score	2020 Final Review Score	5-Star Rating
Allison Care Center	75	72	5
Alpine Living Center	74	65	2
Amberwood Court Rehabilitation and Care Community	90	88	4
Applewood Living Center	91	83	2
Arborview Senior Community	74	71	4
Arvada Care and Rehabilitation Center	81	75	5
Autumn Heights Health Care Center	89	86	3
Avamere Transitional Care and Rehabilitation- Brighton	77	76	3
Avamere Transitional Care and Rehabilitation- Malley	83	81	2
Bent County Healthcare Center	88	88	5

Table 1. CMS 5-Star Rating Data with 2020 P4P Scores.			
Facility Name	**2020 Self Score**	**2020 Final Review Score**	**5-Star Rating**
Berthoud Living Center	74	57	2
Beth Israel at Shalom Park	90	81	5
Boulder Manor	71	54	1
Briarwood Health Care Center	64	49	4
Brookshire House Rehabilitation and Care Community	94	79	5
Brookside Inn	87	87	5
Broomfield Skilled Nursing and Rehabilitation Center	82	82	3
Bruce McCandless CO State Veterans Nursing Home	82	74	5
Cambridge Care Center	80	82	4
Casey's Pond Senior Living LTC	70	70	5
Castle Peak Senior Life and Rehabilitation	86	72	5
Castle Rock Care Center	14	14	1
Cedarwood Health Care Center	88	88	2
Centennial Health Care Center	89	86	4
Centura Health- Medalion Health Center	65	65	2
Centura Health- Progressive Care Center	49	32	3
Cherrelyn Healthcare Center	47	38	2
Cherry Creek Nursing Center	92	89	2
Cheyenne Mountain Center	79	66	2
Christian Living Communities Suites at Someren Glen Care Center	64	51	4
Christopher House Rehabilitation and Care Community	83	83	2
Clear Creek Care Center	70	70	5
Colonial Columns Nursing Center	89	89	3
Colorado State Veterans Nursing Home- Rifle	86	76	5
Colorado Veterans Community Living Center at Homelake	65	63	4
Colorow Care Center	75	77	4
Columbine West Health and Rehab Facility	72	64	5
Cottonwood Care Center	93	91	4
Denver North Care Center	83	80	4
E Dene Moore Care Center	78	79	5
Eben Ezer Lutheran Care Center	84	81	4
Elms Haven Center	88	63	2
Englewood Post Acute and Rehabilitation	83	81	5
Fairacres Manor, Inc.	79	76	5
Forest Ridge Senior Living, LLC	81	69	5
Fort Collins Health Care Center	80	67	1
Four Corners Health Care Center	82	82	3
Glenwood Springs Health Care	52	14	1
Golden Peaks Center	78	63	2

Table 1. CMS 5-Star Rating Data with 2020 P4P Scores.			
Facility Name	**2020 Self Score**	**2020 Final Review Score**	**5-Star Rating**
Grace Manor Care Center	77	41	5
Harmony Pointe Nursing Center	85	74	3
Health Center at Franklin Park	85	85	5
Highline Rehabilitation and Care Community	83	81	5
Holly Heights Care Center	94	94	5
Holly Nursing Care Center	77	69	4
Horizons Care Center	59	59	2
Jewell Care Center of Denver	81	80	3
Julia Temple Healthcare Center	87	87	5
Juniper Village- The Spearly Center	88	85	3
La Villa Grande Care Center	70	55	5
Lakewood Villa	65	65	1
Larchwood Inns	85	83	5
Laurel Manor Care Center	72	74	3
Lemay Avenue Health and Rehabilitation Facility	53	48	5
Life Care Center of Littleton	67	35	4
Littleton Care and Rehabilitation Center	70	65	5
Mesa Vista of Boulder	95	81	3
Minnequa Medicenter	86	83	2
Monaco Parkway Health and Rehabilitation Center	85	80	2
Mount St Francis Nursing Center	86	81	5
Mountain Vista Health Center	63	46	2
North Shore Health and Rehab Facility	66	66	5
North Star Rehabilitation and Care Community	80	80	3
Palisades Living Center	82	70	1
Paonia Care and Rehabilitation Center	89	83	3
Park Forest Care Center, Inc.	64	59	3
Parkmoor Village Healthcare Center	73	75	2
Parkview Care Center	83	83	4
Pearl Street Health and Rehabilitation Center	86	86	2
Pikes Peak Center	82	77	2
Pine Ridge Extended Care Center	83	75	4
Pioneer Health Care Center	51	46	1
Pueblo Center	62	41	1
Regent Park Nursing and Rehabilitation	80	45	5
Rehabilitation Center at Sandalwood	80	71	5
Rio Grande Inn	86	83	2
River Valley Inn Nursing Home	37	37	3
Rock Canyon Respiratory and Rehabilitation Center	87	64	1

Table 1. CMS 5-Star Rating Data with 2020 P4P Scores.			
Facility Name	**2020 Self Score**	**2020 Final Review Score**	**5-Star Rating**
Rowan Community, Inc	88	81	5
San Juan Living Center	88	82	2
Sandrock Ridge Care and Rehab	80	78	4
Sierra Rehabilitation and Care Community	83	83	4
Sierra Vista Health Care Center	66	62	4
Skyline Ridge Nursing and Rehabilitation Center	68	49	5
Spanish Peaks Veterans Community Living Center	79	78	3
Spring Village Care Center	70	58	5
St Paul Health Center	82	73	2
Suites at Clermont Park Care Center	74	62	4
Summit Rehabilitation and Care Community	89	83	4
Sundance Skilled Nursing and Rehabilitation	63	57	3
Sunset Manor	77	77	3
Terrace Gardens Health Care Center	89	89	2
The Gardens	46	42	5
The Green House Homes at Mirasol	81	81	5
The Pavillion at Villa Pueblo	81	70	3
The Peaks Care Center	50	50	1
The Valley Inn	83	81	4
The Villas at Sunny Acres	77	77	4
Trinidad Inn Nursing Home	86	84	2
Uptown Health Care Center	73	73	4
Valley Manor Care Center	79	79	4
Valley View Health Care Center Inc.	96	89	4
Villa Manor Care Center	81	68	5
Vista Grande Inn	68	68	5
Walsh Healthcare Center	75	75	4
Washington County Nursing Home	48	43	3
Western Hills Health Care Center	72	53	5
Westlake Care Community	93	84	5
Wheatridge Manor Care Center	72	62	5
Willow Tree Care Center	28	26	4
Windsor Health Care Center	82	82	3
Yuma Life Care Center	81	81	2
Cottonwood Inn Rehabilitation and Extended Care Center	80	77	5
Forest Street Compassionate Care Center	93	66	5
Mesa Manor Center	71	61	3

Furthermore, looking at average final scores and (range) across the star ratings the average final application score for 1-star facilities is 48.5 (range: 14-70), 2-star facilities is 73.6 (range: 38-89), 3-star facilities is 71.3 (range: 32-89), 4-star facilities is 72.2 (range: 26-91), and 5-star facilities is 70.8 (range: 41-94). These can be found in Table 2. Based on this analysis, CMS 5-star rating is not necessarily a useful predictive indicator of success on the P4P application. While there is not an upward linear trend, the 1-star facilities have lower P4P scores than those facilities with higher star ratings.

Table 2. 5-Star Ratings and P4P Score Average and Range.

5-Star Rating	P4P Score Average	P4P Score Range
1	48.5	14-70
2	73.6	38-89
3	71.3	32-89
4	72.2	26-91
5	70.8	41-94

7. RECOMMENDATIONS

A summary of the recommendations and considerations outlined in this report are as follows:

The recommendations have also been sorted into categories to allow for more efficient discussion and task delegation. The categories are application recommendations, portal recommendations, and programmatic recommendations. The sorted recommendations can be found in Table 3.

Recommendation 1: *Review documentation requirement language throughout the application to specify stronger documentation requirements such as images, signed testimonials, sign-in sheets, etc.*

Recommendation 2: *For all measures, review calculation methodology and tools, even when only qualifying thresholds are changed.*

Recommendation 3: *Instruct facilities to clearly identify their calculation methodology for rehospitalization rates and enter the data into a tool to increase reviewer accuracy.*

Recommendation 4: *Add an upper turnover rate threshold and specify an improvement threshold for Measure 21 to ensure improved rates are more closely linked to improved performance.*

Recommendation 5: *Create a tool to collect statistics required in Measure 6 for better data reporting capabilities.*

Recommendation 6: *Modify minimum requirement 13-3 to be clearer by removing the last line. No specific data from the CASPER Characteristics Report is required to be submitted separately.*

Recommendation 7*: Group the Measure 16.2-16.8 documentation upload dropdown together. This will increase clarity for which measure facilities should upload their CASPER reports.*

Recommendation 8: *Create a tool to collect data required in Measure 17.2 for better data reporting capabilities and to facilitate accurate review decisions.*

Recommendation 9: *Remove minimum requirement 18-2.*

Recommendation 10: *Create a "Not Applying" dropdown option for Measure 19 for greater clarity.*

Recommendation 11: *Update the tool in Measure 19 to save if either section is completed as both sections are not required or update minimum requirement 19-1 instructions to input zeroes for the section not applicable.*

Recommendation 12: *Clarify or remove documentation requirements for Measure 20.*

Recommendation 13: *Clarify or remove documentation requirements for Measure 21.*

Recommendation 14: *Continue to monitor user experience with the application web portal to identify common issues experienced by the nursing home facilities and reviewers. Enhancements to the web portal can lessen administrative burden and streamline the application and review process.*

Recommendation 15: *Explore a review process to identify corrupted files within the preliminary review process. While not a frequent problem, it does delay the review of some facilities.*

Recommendation 16: *Create a secondary or management contact field for each facility to serve as an extra point of contact and ensure program communication is received by facilities****.***

Recommendation 17: *Reach out to nursing facilities that have created an account on the web portal but did not submit an application in the 2020 P4P program or nursing facilities that did not reapply for the program. Engage these homes through a short survey and follow up as necessary to collect information around barriers to participation.*

Recommendation 18: *Continue to monitor the performance of Colorado P4P facilities in the FY2020 SNF VBP.*

Recommendation 19: *Since preventable hospital readmissions are the primary focus in SNF VBP, reevaluate how hospital readmissions are currently scored in the Colorado P4P program.*

Recommendation 20: *Explore dedicating funds for rewarding nursing facilities who show an improvement in their application scores. This would be a modification of California's structured payment program. Specific to Colorado, the Department could potentially provide a financial incentive for homes who score 0-20 points, thus not meeting the threshold to receive any per diem add on. These homes may be discouraged from applying. Some amount of financial incentive to encourage the home to continue building its program to meet P4P measures may increase program participation in future years.*

Table 3. Summary of Recommendations by Category.		
Application	**Portal**	**Programmatic**
Recommendation 1: *Review documentation requirement language throughout the application to specify stronger documentation requirements such as images, signed testimonials, sign-in sheets, etc.* ***Recommendation 2:*** *For all measures, review calculation methodology and tools, even when only qualifying thresholds are changed.* ***Recommendation 3:*** *Instruct facilities to clearly identify their calculation methodology for rehospitalization rates and enter the data into a tool to increase reviewer accuracy.* ***Recommendation 4:*** *Add an upper turnover rate threshold and specify an improvement threshold for Measure 21 to ensure improved rates are more closely linked to improved performance.* ***Recommendation 6:*** *Modify minimum requirement 13-3 to be clearer by removing the last line. No specific data from the CASPER Characteristics Report is required to be submitted separately.* ***Recommendation 9:*** *Remove minimum requirement 18-2.* ***Recommendation 12:*** *Clarify or remove documentation requirements for Measure 20.* ***Recommendation 13:*** *Clarify or remove documentation requirements for Measure 21.*	***Recommendation 5:*** *Create a tool to collect statistics required in Measure 6 for better data reporting capabilities.* ***Recommendation 7****: Group the Measure 16.2-16.8 documentation upload dropdown together. This will increase clarity for which measure facilities should upload their CASPER reports.* ***Recommendation 8:*** *Create a tool to collect data required in Measure 17.2 for better data reporting capabilities and to facilitate accurate review decisions.* ***Recommendation 10:*** *Create a "Not Applying" dropdown option for Measure 19 for greater clarity.* ***Recommendation 11:*** *Update the tool in Measure 19 to save if either section is completed as both sections are not required or update minimum requirement 19-1 instructions to input zeroes for the section not applicable.* ***Recommendation 14:*** *Continue to monitor user experience with the application web portal to identify common issues experienced by the nursing home facilities and reviewers. Enhancements to the web portal can lessen administrative burden and streamline the application and review process.* ***Recommendation 15:*** *Explore a review process to identify corrupted files within the preliminary review process. While not a*	***Recommendation 20:*** *Explore dedicating funds for rewarding nursing facilities who show an improvement in their application scores. This would be a modification of California's structured payment program. Specific to Colorado, the Department could potentially provide a financial incentive for homes who score 0-20 points, thus not meeting the threshold to receive any per diem add on. These homes may be discouraged from applying. Some amount of financial incentive to encourage the home to continue building its program to meet P4P measures may increase program participation in future years.* ***Recommendation 17:*** *Reach out to nursing facilities that have created an account on the web portal but did not submit an application in the 2020 P4P program or nursing facilities that did not reapply for the program. Engage these homes through a short survey and follow up as necessary to collect information around barriers to participation.* **Recommendation 18:** *Continue to monitor the performance of Colorado P4P facilities in the FY2020 SNF VBP.* ***Recommendation 19:*** *Since preventable hospital readmissions are the primary focus in SNF VBP, reevaluate how hospital readmissions are currently scored in the Colorado P4P program.* .

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Application	**Portal**	**Programmatic**
	frequent problem, it does delay the review of some facilities. ***Recommendation 16:*** *Create a secondary or management contact field for each facility to serve as an extra point of contact and ensure program communication is received by facilities.*	